

BEFORE THE  
BOARD OF REGISTERED NURSING  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

**CINDY A. FEE**

Respondent.

Case No. 2007-276

OAH No. 2007110198

**DECISION**

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on June 5, 2008.

IT IS SO ORDERED this 5<sup>th</sup> day of MAY, 2008.

*LaTranene W Tate*

\_\_\_\_\_  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California

BEFORE THE  
BOARD OF REGISTERED NURSING  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation against:

CINDY A. FEE  
a.k.a. CINDY ANN FEE,

Respondent.

Case No. 2007-276

OAH No. N2007110198

**PROPOSED DECISION**

Gary A. Geren, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on February 5, 2008, in Sacramento, California.

Arthur D. Taggart, Supervising Deputy Attorney General, represented Complainant.

Cindy A. Fec, respondent, represented herself.

The matter was submitted on February 5, 2008.

**FACTUAL FINDINGS**

1. Complainant, Ruth Ann Terry, Executive Officer of the Board of Registered Nursing, made the Accusation and First Amended Accusation while acting in her official capacity.

2. On April 14, 1999, the Board issued Registered Nurse License Number 554190 to respondent. The license will expire on May 31, 2009, unless renewed.

3. On November 17, 2004, pursuant to Findings of Fact, Conclusions of Law, and Order No. 03A-0004019-NUR issued by the Arizona State Board of Nursing (Arizona Board), respondent's Arizona nursing license, No. RN 080648 was revoked. Respondent filed a Motion for Rehearing on November 27 and 30, 2004. On January 19, 2005, the

Arizona Board issued an Order Denying Respondent's Motion for Rehearing. The Arizona Board's revocation of respondent's license is a final administrative decision.

4. The Arizona Board found that respondent committed acts constituting unprofessional conduct, in that she engaged in conduct that was or might have been harmful to the health of patients or the public; engaged in a pattern of failing to maintain minimum standards of acceptable and prevailing nursing practice; assumed patient care responsibilities for which she lacked the education to perform or for which she failed to maintain nursing competency; and practiced in a manner that provided reasonable cause to believe that the health of a patient or the public may be harmed.

5. The basic facts on which the Arizona Board made its findings were as follows:

From August 27, 1997, through January 21, 1999, respondent was employed on a per diem basis by Desert Samaritan Surgicenter in Mesa, Arizona. She was ultimately terminated because of poor behavior (such as, the use of inappropriate language and inappropriate remarks made in the operating room) and unprofessional conduct (such as, inattentiveness to children during intubation or emergence from anesthesia, handing surgeons a needle holder while it was upside down and the critical mislabeling of a pathology specimen).

From November 21, 1999, through March 11, 2000, respondent was employed by the Veterans Affairs Medical Center in Phoenix, Arizona. Respondent failed to pass her probationary period because of deficiencies in her operating room knowledge and practice; incomplete patient assessments; an inability to incorporate data from patients into a nursing plan of care; and an inability to identify and communicate relevant data to the surgical team. Respondent also suffered from deficiencies in her ability to practice independently and on multiple occasions engaged in unprofessional conduct, including verbal threats of physical harm directed at her supervisors.

On January 8, 2003, respondent was assessed pursuant to an Arizona Board-ordered psychological evaluation. The evaluator concluded that respondent was inattentive to following instructions, argumentative with her superiors, had difficulty following through with instructions, and was unwilling to accept responsibility for her errors. The evaluator recommended that respondent undergo a psychiatric evaluation to determine if she had an underlying mood disorder and/or whether she needed psychopharmacologic medication.

6. Respondent offered little evidence to mitigate the revocation by the Arizona Board or to establish her rehabilitation. Respondent's testimony lacked coherency, the only consistent thread being that she believes she has been victimized by past supervisors and the Arizona Board. She stated that the "Arizona Board was taking licenses left and right," and she is going to pursue a "class action against the Arizona Board." Respondent asserted that the Arizona Board's decision was rendered without giving her proper notice. Respondent testified that she had records in storage that would corroborate each of her contentions; however, she cannot gain access to those records because they are in "nowhere land." The

BOARD OF REGISTERED NURSING

MAR 12 2008

tone in respondent's voice was unnecessarily hostile. Respondent believes her supervisors at the Veterans Affairs Medical Center, who did not like her, are the cause of her problems with the Arizona Board. Respondent did not explain why she had problems with her prior employer.

7. Respondent is now homeless and lacks the financial wherewithal to pay the costs the Board seeks.

### LEGAL CONCLUSIONS

1. Business and Professions Code, section 2750, provides that the Board may discipline a licensee for violations of the Nursing Practice Act (Act).

2. Business and Professions Code, section 2761, subdivision (a)(4), provides that the Board may take disciplinary action against a licensee for unprofessional conduct, which includes, when a licensee has had his or her license revoked by another state.

3. Business and Professions Code, section 125.3, provides that the Board may request the administrative law judge to direct a licensee found to have committed a violation of the Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. As set forth in Factual Findings, 1 through 6, and Legal Conclusions, 1 through 2, the Board has legal cause to take discipline against respondent's license based on her unprofessional conduct as evidenced by the Arizona Board's revocation of her nursing license.


5. *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, set forth four factors required to be considered when deciding whether to reduce or eliminate costs: (1) Whether the licentiate used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; (2) whether the licentiate had a "subjective" good faith belief in the merits of his position; (3) whether the licentiate raised a "colorable challenge" to the proposed discipline; and (4) whether the licentiate had the financial ability to make payments. Complainant did not establish evidence to support factor four, as set forth in Factual Finding 7.

6. In light of the Arizona Board's revocation, the serious nature of respondent's conduct underlying the revocation, and respondent's failure to produce meaningful evidence in mitigation or rehabilitation, the outright revocation of respondent's license is necessary in order to ensure public safety.

ORDER

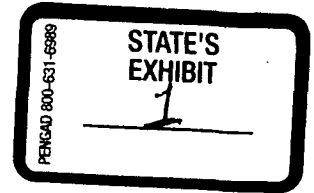
Registered Nurse License Number 554190 issued to respondent Cindy A. Fee, also known as Cindy Ann Fee, is hereby revoked.

DATED: March 3, 2008

  
GARY A. GERAN  
Administrative Law Judge  
Office of Administrative Hearings

BOARD OF REGISTERED NURSING

MAR 12 2008



EDMUND G. BROWN JR., Attorney General  
of the State of California  
ALFREDO TERRAZAS  
Senior Assistant Attorney General  
ARTHUR D. TAGGART, State Bar No. 83047  
Supervising Deputy Attorney General  
California Department of Justice  
1300 I Street, Suite 125  
P.O. Box 944255  
Sacramento, CA 94244-2550  
Telephone: (916) 324-5339  
Facsimile: (916) 327-8643

Attorneys for Complainant

**BEFORE THE  
BOARD OF REGISTERED NURSING  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

Case No. 2007-276

CINDY A. FEE,  
a.k.a. CINDY ANN FEE  
125 Oakcrest Avenue  
Pitman, NJ 08071

**FIRST AMENDED  
ACCUSATION**

Registered Nurse License No. 554190,

Respondent.

Complainant alleges:

**PARTIES**

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about April 14, 1999, the Board issued Registered Nurse License Number 554190 to Cindy A. Fee, also known as Cindy Ann Fee ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2009, unless renewed.

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1 titled *In the Matter of Professional Nurse License No. RN080648 Issued to: Cindy Ann Fee*, the  
2 Arizona Board revoked License No. RN080648 issued to Respondent.<sup>1/</sup> Respondent filed a  
3 Motion for Rehearing on November 27, and November 30, 2004. On or about January 19, 2005,  
4 the Arizona Board issued an Order Denying Respondent's Motion for Rehearing in the matter,  
5 therefore constituting a final administrative decision of the Board revoking Respondent's  
6 License No. RN080648. A true and correct copy of the Findings of Fact, Conclusions of Law  
7 and Order is attached as exhibit "A" and incorporated herein by reference. A true and correct  
8 copy of the Order Denying Respondent's Motion for Rehearing is attached as exhibit "B" and  
9 incorporated herein by reference.

10 8. Pursuant to the Findings of Fact, Conclusions of Law and Order, the  
11 Arizona Board found that Respondent committed acts constituting unprofessional conduct, in  
12 violation of A.R.S. § 32-1601(16)(d) (any conduct or practice that is or might be harmful or  
13 dangerous to health of a patient or the public); A.R.S. § 32-1601(16)(j) (violating a rule that is  
14 adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(1), a pattern of  
15 failure to maintain minimum standards of acceptable and prevailing nursing practice; A.R.S. §  
16 32-1601(16)(j) (violating a rule that is adopted by the board pursuant to this chapter, specifically,  
17 A.A.C. R4-19-403 (9), assuming patient care responsibilities for which the nurse lacks education  
18 to perform or for which the nurse has failed to maintain nursing competence; and A.R.S. § 32-  
19 1601(16)(j) (violating a rule that is adopted by the board pursuant to this chapter, specifically,  
20 A.A.C. R4-19-403(25), practicing in any other manner which gives the Board reasonable cause  
21 to believe that the health of a patient or the public may be harmed.

#### 22 PRAYER

23 WHEREFORE, Complainant requests that a hearing be held on the matters  
24 herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

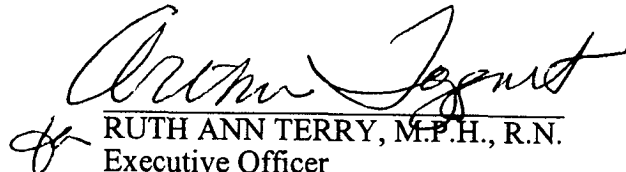
25 1. Revoking or suspending Registered Nurse License Number 554190,  
26 issued to Cindy A. Fee, also known as Cindy Ann Fee;

27  
28 <sup>1</sup>. The Arizona Board's decision was to be effective upon expiration of the time for filing a request for  
rehearing or review, or upon denial of such request, whichever was later, as mandated in A.A.C. R4-19-609.

1                   2.       Ordering Cindy A. Fee, also known as Cindy Ann Fee, to pay the Board  
2 of Registered Nursing the reasonable costs of the investigation and enforcement of this case,  
3 pursuant to Business and Professions Code section 125.3; and

4                   3.       Taking such other and further action as deemed necessary.  
5

6 DATED: June 13, 2007  
7

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9   
10 RUTH ANN TERRY, M.P.H., R.N.  
11 Executive Officer  
12 Board of Registered Nursing  
13 Department of Consumer Affairs  
14 State of California  
15 Complainant  
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**EXHIBIT A**  
**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 03A-0004019-NUR**

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**ARIZONA STATE BOARD OF NURSING**  
**1651 East Morten Avenue, Suite 210**  
**Phoenix, Arizona 85020**  
**602-889-5150**

IN THE MATTER OF PROFESSIONAL  
NURSE LICENSE NO. RN080648  
ISSUED TO:

CINDY ANN FEE,  
  
Respondent.

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER NO. 03A-0004019-NUR**

On November 17, 2004, the Arizona State Board of Nursing ("Board") considered the State's Motion to Deem Allegations Admitted and Respondent's Response to the Motion, if any, at the Arizona State Board of Nursing Conference Room, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona. Melissa S. Cornelius, Assistant Attorney General, appeared on behalf of the State. Respondent was not present and was not represented by counsel.

On November 17, 2004, the Board granted the State's Motion to Deem Allegations Admitted. Based upon A.R.S. § 32-1664(I) and the Complaint and Notice of Hearing No. 03A-0004019-NUR filed in this matter, the Board adopts the following Findings of Fact and Conclusions of Law, and revokes Respondent's license.

**FINDINGS OF FACT**

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§32-1606, 32-1663, and 32-1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses/nursing assistant certificates for violations of the Nurse Practice Act, A.R.S. §§32-1601 to - 1667.

2. Cindy Ann Fee ("Respondent") holds Board issued professional nurse license number RN080648.

1                   3.       From on or about August 27, 1997 through January 21, 1999, Respondent was  
2 employed on a per diem basis (pool) by Desert Samaritan Surgicenter ("Desert Samaritan"), Mesa,  
3 Arizona. On or about November 6, 1997, Respondent was counseled for brash and/or loud behavior,  
4 inappropriate language, statements of dislike of children, inattentiveness to children during intubation  
5 or emergence from anesthesia, handing surgeons the needle holder upside down, inappropriate  
6 remarks made in the operating room increasing room tension, and critical mislabeling of a pathology  
7 specimen prior to sending it to the lab. Desert Samaritan stopped assigning Respondent after January  
8 8, 1998, and terminated her employment from the pool on January 21, 1999.  
9  
10

11                   4.       On or about November 21, 1999, Respondent began employment with the  
12 Veteran's Affairs Medical Center ("VAMC"), Phoenix, Arizona.  
13

14                   5.       On or about December 15, 17, 20 and 21, 1999, and February 1, 2000, during  
15 Respondent's orientation with a preceptor, the VAMC documented Respondent's unsatisfactory  
16 performance on multiple operating room cases. A December 17, 1999 anecdotal note in her personnel  
17 file reflected that Respondent was informed of her unsatisfactory performance.  
18

19                   6.       On or about January 26, 2000, the VAMC Professional Standards Board  
20 recommended that Respondent's orientation be continued based upon concerns over her skill level; her  
21 poor attitude towards her work; her apparent lack of ability to work in a cooperative environment that  
22 the work in an operating room environment demanded, and her questionable conduct." The Director  
23 allowed Respondent's orientation to continue under close monitoring by supervisors and experienced  
24 preceptors, and required a further Summary Review Board to review her progress at the end of  
25 orientation.  
26

27                   7.       An anecdotal note in her personnel file for February 1, 2000 through March 3,  
28 2000, reflected deficiencies in Respondent's practice, including: her failure to check patient  
29

1 history/physical for pertinent information; inability to prioritize; inadequate knowledge of instruments  
2 and procedures; that she did not take constructive criticism; had almost non-existent team  
3 communication; and was unaware of basic concepts of sterile boundaries.  
4

5 8. A February 3, 2000, anecdotal note reflected that Respondent was informed of  
6 her unsatisfactory performance and asked to sign the Director's memo.

7 9. On or about February 10, 2000, Respondent received a Written Counseling for  
8 her Leave Usage.  
9

10 10. On or about February 15, 2000, Respondent received a Verbal Counseling for  
11 Leaving the Department without Notification.

12 11. On or about March 3, 2000, the VAMC placed Respondent on Administrative  
13 Leave pending the Professional Standards Board meeting.  
14

15 12. A March 21, 2000, Memorandum from the Professional Standards Board to the  
16 Director reflected that the Summary Probationary Review Board conducted a summary review of  
17 Respondent's probationary period on March 21, 2000, to which Respondent was invited to present  
18 information but failed to appear. The Review Board identified the following findings:  
19

20 1. *Deficiencies in operating room nursing knowledge and practice.* Respondent had  
21 been on a performance action plan for 6 weeks, but had failed to take it upon herself to  
22 learn and was unwilling to ask for assistance.

23 2. *Deficiencies in utilizing the nursing process as evidenced in incomplete patient*  
24 *assessments, inability to incorporate data from patients' assessments into the nursing*  
25 *plan of care, and inability to identify and communicate relevant data to the surgical*  
26 *team.*  
27  
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1 *Examples given were Respondent's failure to communicate a patient's history of*  
2 *hepatitis to the surgical team, and failure to communicate or document a patient's*  
3 *seizure history secondary to alcohol.*

4  
5 3. *Deficiencies in ability to practice independently.* Respondent was unable to  
6 anticipate and prioritize multiple tasks, and did not seek assistance.

7 4. *Professional conduct.* The Standards Board reviewed a Uniform Offense Report  
8 (UOR#00-02-22-1000) that documented a verbal threat of physical harm that  
9 Respondent directed at her preceptor on February 28, 2000. A nurse anesthetist  
10 overheard Respondent's threat of physical harm, "I'm going to kill that bitch," in  
11 reference to Respondent's preceptor. When the nurse anesthetist confronted  
12 Respondent about the comment, Respondent replied that she, (Respondent), was going  
13 to take her (preceptor) out back and beat her. The anesthetist reported the incident to  
14 the nurse manager. The Offense Report reflected that Respondent stated, "That bitch is  
15 killing me." A further incident included a contact from Respondent to an Employee  
16 Relations Specialist after receiving notice of summary probation review. The employee  
17 stated Respondent was extremely angry and stated that a Nurse Manager in the  
18 Operating Room is "fucking incompetent and that she was going to get her."  
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20  
21 13. An April 11, 2000 Professional Standards Board Action reflected Respondent  
22 was not to be retained in her position. The Board had reconvened to provide Respondent with an  
23 opportunity to present information, however Respondent declined to permit VAMC police to search  
24 her bag, or to leave her bag outside of the room; Respondent then failed to appear before the  
25 Professional Standards Board.  
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1           14.     On or about January 8, 2003, Respondent submitted to a Board-ordered  
2 psychological evaluation to assess her anger management and judgment. The evaluator opined that  
3 Respondent was inattentive to instructions, argumentative with her superiors, had difficulty following  
4 through with instructions, was unwilling to accept responsibility for her errors, and recommended that  
5 Respondent undergo a psychiatric evaluation to determine if she had an underlying mood disorder and  
6 to determine whether she needed psychopharmacologic interventions and psychotherapy. The  
7 evaluator further recommended that Respondent not practice nursing until she submitted to further  
8 psychiatric evaluation.  
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11           15.     Respondent's conduct and nursing practice at the VAMC and Desert Samaritan  
12 fell below the standard of care, was or may have been harmful or dangerous to the health of her  
13 patients or was inadequate.  
14

#### 15                           CONCLUSIONS OF LAW

16           1.     The conduct and circumstances alleged in the Factual Allegations alleged  
17 constitute violations of A.R.S. §32-1663(D), as defined in A.R.S. §32-1601(14)(d) and (j), currently  
18 cited as A.R.S. §32-1601(16)(d) and (j)(amended 2002), and A.A.C. R4-19-403 (1), (9), (25).  
19

20           2.     The conduct and circumstances described in paragraphs 3 through 15 of the  
21 Factual Allegations constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(d), (any  
22 conduct or practice that is or might be harmful or dangerous to the health of a patient or the public),  
23 and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.  
24

25           3.     The conduct and circumstances described in paragraphs 3 through 15 of the  
26 Factual Allegations constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a  
27 rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403 (1), a pattern  
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1 of failure to maintain minimum standards of acceptable and prevailing nursing practice, and is grounds  
2 for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

3  
4 4. The conduct and circumstances described in paragraphs 3 through 15 of the  
5 Factual Allegations constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a  
6 rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403 (9), assuming  
7 patient care responsibilities for which the nurse lacks the education to perform or for which the nurse  
8 has failed to maintain nursing competence, and is grounds for disciplinary action pursuant to A.R.S.  
9 §32-1663 and §32-1664.

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11 5. The conduct and circumstances described in paragraphs 3 through 15 of the  
12 Factual Allegations constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a  
13 rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403 (25),  
14 practicing in any other manner which gives the Board reasonable cause to believe that the health of a  
15 patient or the public may be harmed, and is grounds for disciplinary action pursuant to A.R.S. §32-1663  
16 and §32-1664.

17  
18 6. The conduct and circumstances described in the Findings of Fact constitute  
19 sufficient cause pursuant to A.R.S. § 32-1664(N) to suspend or revoke the license of Cindy Ann Fee to  
20 practice as a professional nurse in the State of Arizona.

### 21 ORDER

22  
23 In view of the above Findings of Fact and Conclusions of Law, the Board issues the  
24 following Order:

25  
26 Pursuant to A.R.S. § 32-1664(N), the Board revokes professional nursing license  
27 number RN080648 issued to Cindy Ann Fee.

Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing or review within 30 days after service of this decision with the Arizona State Board of Nursing. The motion for rehearing or review shall be made to the attention of Susan Barber, R.N., M.S.N., Arizona State Board of Nursing, 1651 E. Morten, Ste. 210, Phoenix AZ 85020. For answers to questions regarding a rehearing, contact Susan Barber at (602) 889-5161. Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review within 30 days after service of this decision, Respondent shall be prohibited from seeking judicial review of this decision.

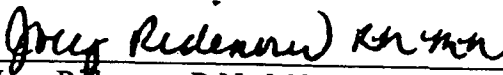
This decision is effective upon expiration of the time for filing a request for rehearing or review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.

Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after a period of five years.

DATED this 17<sup>th</sup> day of November, 2004.

SEAL

ARIZONA STATE BOARD OF NURSING

  
Joey Ridenour, R.N., M.N.  
Executive Director

COPIES mailed this 24<sup>th</sup> day of November, 2004, by Certified Mail No. 7001 1940 0003 4508 2123 and First Class Mail to:

Cindy Ann Fee  
2019 W Lemontree Pl #1190  
Chandler AZ 85224

COPIES of the foregoing mailed this 24<sup>th</sup> day of November, 2004, to:

Melissa S. Cornelius  
Assistant Attorney General  
1275 W. Washington, LES Section  
Phoenix, AZ 85007

By: Vicky Driver

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**EXHIBIT B**  
**ORDER DENYING RESPONDENT’S MOTION FOR REHEARING**

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**ARIZONA STATE BOARD OF NURSING**  
**1651 East Morten Avenue, Suite 210**  
**Phoenix, Arizona 85020**  
**602-889-5150**

IN THE MATTER OF PROFESSIONAL NURSE  
LICENSE NO. RN080648  
ISSUED TO:

CINDY ANN FEE,

Respondent.

CASE NO. 03A-0004019-NUR

**ORDER DENYING RESPONDENT'S  
MOTION FOR REHEARING**

Cindy Ann Fee ("Respondent") filed a Motion for Rehearing in the above-entitled matter on November 27, and November 30, 2004. The State filed a Response on December 27, 2004.

On January 19, 2005, after hearing oral arguments of counsel, reviewing and considering Respondent's Motion and the State's Response, the Arizona State Board of Nursing denied Respondent's Motion for Rehearing because Respondent failed to meet the standards established in A.A.C. R4-19-608. For answers to questions regarding the Order Denying Respondent's Motion for Rehearing, contact Susan Barber, R.N., M.S.N., at (602) 889-5161.

This Order constitutes a final administrative decision of the Board which is reviewable by the Superior Court pursuant to A.R.S. §§ 12-901 through 12-914. This decision is binding on Respondent from the date of the Board's denial of the Motion For Rehearing as mandated in A.A.C. R4-19-609 unless and until Respondent secures a Stay Order from Superior Court.

DATED this 19th day of January, 2005.

SEAL

ARIZONA STATE BOARD OF NURSING

*Joey Ridenour*

Joey Ridenour, R.N., M.N.  
Executive Director

1  
2 COPIES mailed this 28<sup>th</sup> day of January 2005. by Certified Mail No. 7001 1940 0003 4510 0827 and  
3 First Class Mail to:

4 Cindy Ann Fee  
5 2019 W Lemontree Pl #1190  
6 Chandler AZ 85224

7 COPY mailed this 28<sup>th</sup> day of January 2005, to:

8 Melissa S. Cornélius  
9 Assistant Attorney General  
10 1275 W. Washington  
11 Phoenix, AZ 85007

12 By: Vicky Driver  
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